Please keep this booklet for future reference.

Visit us on the Web at:

www.state.sd.us/social/medical

DSS Nondiscrimination Policy:
It is the policy of the Department of Social Services (DSS) to make sure that applications for program benefits and services are made available to everyone and that program benefits are granted to all who meet eligibility standards. DSS staff, programs and policies must not discriminate against clients or applicants for services because of race, color, sex, age, disability, religion and national origin. DSS must also provide fair and equal access to all of its programs and services for people with disabilities; this includes both physical access to buildings and access to programs and services. To file a complaint of discrimination write: DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or call: (605) 773-3305. If you have a question regarding program services, please contact your nearest DSS office.

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SOUTH DAKOTA

Medical Assistance Program

Recipient Handbook

Department of Social Services

South Dakota

Medical Assistance Program

Welcome

This booklet contains important information that will answer many of your questions about the South Dakota Medical Assistance Program. The Medical Assistance Program provides health coverage to individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP).

Please keep this booklet in a safe place for future reference. If you have questions regarding eligibility, please call your local Department of Social Services (DSS) office or caseworker. If you have questions about covered medical services, please call the SD Department of Social Services, Division of Medical Services at (605) 773-3495.

This handbook and much more is available on our Web site. At our site, you can find managed care selection and change forms, a list of primary care providers, frequently asked questions, program rules and regulations, and links to other useful sites. Visit us on the Web at:

www.state.sd.us/social/medical

Please keep this booklet for future reference.

Phone Numbers and Web Sites

Phone Numbers

Division of Medical Services . . . . . (605) 773-3495
Office of Recoveries and Fraud Investigations . . . . . (605) 773-3653
Office of Administrative Hearings . . . . . (605) 773-6851
Fraud Tip Hotline 1-800-765-7867
Department of Health 1-800-738-2301

Web Sites

Medical Services . . . . . www.state.sd.us/social/medical
Medical Eligibility . . . . . www.state.sd.us/social/medelig
Department of Social Services . . . . . www.state.sd.us/social
Department of Health . . . . . www.state.sd.us/doh

Notes

How can I request a Fair Hearing?

If you feel the Department of Social Services made an incorrect eligibility or payment decision, you may request a Fair Hearing by contacting your local Social Services office or by contacting the Office of Administrative Hearings in Pierre at (605) 773-6851. A Fair Hearing is a meeting involving you, a hearing's officer and someone from the Department of Social Services. At the hearing, you will have a chance to explain your problem. If you are currently receiving benefits and request a hearing, you have the right to continue receiving benefits.

What if I feel I've been discriminated against?

The Department of Social Services and your medical provider may not discriminate against you because of your race, color, sex, age, disability, religion and national origin. To file a complaint of discrimination write: DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or call: (605) 773-3305.

Communication Note

Being able to communicate with your medical providers and the Department of Social Services (DSS) is very important. Assistance is available for those that need it.

Let your medical provider or DSS personnel know if you have difficulty understanding the information they are providing you. Interpretation services for limited English proficient (LEP) and physically impaired beneficiaries are available at no cost to you.

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Medical Assistance

What is Medical Assistance?

Medical Assistance is a federal and state-funded program that provides medical coverage for people who meet certain eligibility standards. If you are eligible, Medical Assistance will act as your insurance company and pay for medical services such as visits to the doctor, hospital, dentist and chiropractor.

Who is eligible for Medical Assistance?

In order to be eligible for Medical Assistance, you must meet the eligibility criteria for a program such as the Children's Health Insurance Program (**CHIP**), Low Income Families (**LIF**), Nursing Home Assistance or other Medical Assistance programs. If you receive payments from Supplemental Security Income (**SSI**), you are also eligible for Medical Assistance.

If you already have health insurance, you can also be eligible for Medical Assistance if you meet certain criteria. Medical Assistance may pay for deductibles, co-payments and other medical services not covered by other insurance companies.

Medical Benefits ID Card

You must have your Medical Benefits ID Card anytime you get medical care. You should carry it with you at all times. If you don't present your card when receiving services, you may have to pay the bill. If you lose your card, contact your local DSS office for a new one.

Medical Assistance Fraud and Abuse

Recipient Fraud

Knowingly making false statements or representations to become eligible for Medical Assistance may be considered fraud. Failing to provide all required information (including other insurance coverage) may also be considered fraud. If you commit fraud, you may be prosecuted under state criminal laws and federal fraud and abuse laws.

Provider Fraud

If you notice any charges for medical care you did not receive or if you are billed a balance (other than your cost share) after Medical Assistance has paid, please contact the Division of Medical Services in Pierre at (605) 773-3495.

Fraud Tip Hotline

If you know of someone who is fraudulently receiving Medical Assistance, please call the fraud tip hotline at 1-800-765-7867.

Grievances, Appeals & Fair Hearings

What is a Grievance?

A grievance is a complaint when you feel that something is wrong or not appropriate regarding the Medical Assistance Program or services provided by medical providers. All grievances will be investigated and may be accepted verbally or in writing.

What is an Appeal?

An appeal is an informal written request to overturn a decision. Appeals are defined as complaints related to specific actions taken by either the State or medical providers that result in denial of payment for medical care or denial of medical services. Grievances and Appeals may be submitted by contacting the Division of Medical Services at: 700 Governors Drive, Pierre, SD 57501, (605) 773-3495. Requesting an appeal does not take away your ability to request a Fair Hearing.

Can I be billed for services paid for by the Medical Assistance Program?

The answer is no. When the Medical Assistance Program pays for a covered service, the service is considered paid in full. The provider cannot bill any remaining balance of the covered service to you, your family, friends or anyone else. Providers can only bill for cost-sharing charges allowable under the Medical Assistance Program and for non-covered services.

What is Estate Recovery?

Payments made by the Department of Social Services for medical services may be debts owed to the DSS. The Estate Recovery Program can file claims against the estates of deceased Medical Assistance recipients to recover costs for the following services:

- Nursing facility services (regardless of the recipient's age)
- Home and community-based services (recipients 55 or older)
- Intermediate care facility services for the mentally handicapped (recipients 55 or older)
- Other institutional services (recipients 55 or older)
- Hospital services (recipients 55 or older)
- Prescription drug services (recipients 55 or older)

The above debts may also be recovered from the estate of the surviving spouse of a Medical Assistance recipient. For more information, please contact the Department of Social Services, Office of Recoveries and Fraud Investigations at (605) 773-3653.

Transportation Note

Help may be available for recipients without adequate transportation for medical care. Your local Department of Social Services office may have information regarding possible transportation services or assistance available in your community.

Managed Care

What is Managed Care?

The Managed Care Program is designed to improve your access to medical care as well as improve the quality of care you receive by giving you a medical home. As a managed care recipient, you are required to receive managed care services from your Primary Care Provider (PCP). You are also required to have a referral (permission) from your PCP for most specialty and hospital services. You can receive certain services called Managed Care Exempt Services from other providers without a referral from your PCP. See page 6.

Who must participate in Managed Care?

Recipients eligible for the following programs must participate in managed care:

- Supplemental Security Income (SSI) recipients: blind, disabled people age 19 and older.
- Families eligible for the Low Income Families (LIF) Program.
- Low income children eligible for Medicaid.
- Children eligible for CHIP.
- Women eligible for low income pregnancy coverage.

NOTE: *If you have Medicare or live in an institution like a nursing home, you will not be enrolled in the Managed Care Program.*

Primary Care Provider Responsibilities

Your Primary Care Provider (PCP) is responsible for:

- Coordinating your health care and providing health care services.
- Referring you to specialty providers and authorizing hospital care and other services when medical necessary and not available from your PCP.
- Providing 24-hour, 7-day-a-week access by telephone.
- Respecting your rights.
- Communicating with you about your health care.

Managed Care Enrollment

Choosing Your Primary Care Provider

DSS will notify you if you must choose a Primary Care Provider (PCP). A PCP is a physician or clinic who you must see for most of your medical care. DSS will give you a selection form and a list of PCPs in your area. You need to complete the form by choosing a PCP for each eligible member of your family. If you do not choose a PCP, DSS will choose one for you. Contact the Division of Medical Services at (605) 773-3495 if you have questions or need assistance completing the form. **You can save time by selecting your PCP online. Go to www.state.sd.us/social/medical and select the Managed Care button.**

There are a few things to consider when choosing an appropriate PCP for you and your family.

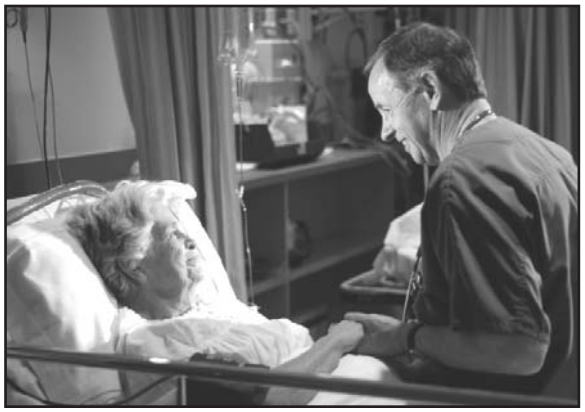
- Pediatricians usually serve only children. OB/GYN providers only serve women and usually for just pregnancy and gynecology services. Internal Medicine doctors usually serve only adults.
- Location: Consider how far you must travel to your PCP. Remember, South Dakota winters can make travel very difficult.
- Some providers have full caseloads and will not accept new patients. This is indicated by an "*" next to the PCP's name on the PCP list. Do not select a PCP with a full caseload unless you are sure that you will be accepted. Check with the PCP's office before you make the selection if you are unsure you will be accepted.
- Special needs: If you or an eligible family member has special health care needs, you should contact the PCP's office before you make your selection to ensure that the provider will meet your needs.

Your chosen or assigned PCP becomes effective the first day of the month after you select or are assigned a PCP. DSS will notify you with the name of your PCP and the date that your enrollment begins. You must receive most of your medical care from your PCP. Your PCP will treat you or refer you to other providers.

What Is the Cost-Share on Various Medical Services?

Following are the cost-share amounts on various medical services.

- **Physician Care (including independent mental health providers):** $3 per visit
- **Prescriptions:** $3 each brand name prescription or refill (**Note:** There is no cost-share on generic medications)
- **Optometric and Optical Services:** $2 for each procedure, lens, frame, exam and repair service
- **Adult Dental:** $3 for each procedure
- **Inpatient Hospital Services:** $50 for each admission



- **Outpatient Hospital Services and Ambulatory Surgical Centers:** 5 percent of allowable reimbursement up to maximum of $50
- **Medical Equipment/Prosthetic Devices:** 5 percent of the allowable reimbursement
- **Covered Chiropractic Services:** $1 for each procedure
- **Podiatry Covered Services:** $2 for each covered procedure
- **Mental Health Clinics:** 5 percent of the allowable reimbursement for each procedure
- **Nutritional Services (21 and older):** $2 a day - enteral, $5 a day - parenteral
- **Diabetes Education:** $3 per unit of service
- **Chemical Dependency Treatment (age 19-21):** Co-pay may be required

Payment of Medical Bills

What If I Have Other Health Insurance?

Your other health insurance is the first source of payment. Medical providers must bill your insurance first before billing Medical Assistance. You **must** report other insurance coverage to your eligibility worker and your doctor, clinic or hospital where you receive medical care.

Who pays for services not covered by the Medical Assistance Program?

Most medical services are covered under the Medical Assistance Program; however, there are some that are not. It is your responsibility to check with your doctor to see if the services you are receiving are covered. If the services are not covered under the Medical Assistance Program, you will be responsible for payment.

What is Cost-Sharing?

Cost-sharing is when you pay a small portion of your medical bill and Medical Assistance pays the rest. Cost-share amounts vary slightly depending on the service provided. Your provider can tell you what your cost-share amounts are for the services you receive.

If you are at least 19 years old and not a resident of a long-term care facility or a recipient of home and community-based services, you must contribute toward cost-sharing. There is no cost share for:

- Services relating to pregnancy
- Family planning
- Nutritional therapy and supplements for recipients under age 21
- Emergency hospital services that meet the criteria of " true emergency"

If you are a Managed Care recipient and you see your PCP, the Medical Assistance Program will pay the cost-share. If you see any medical provider other than your PCP, (even if your PCP refers you to someone else or you see another provider in the same clinic) you will be responsible for the cost-share amount.

Changing your Primary Care Provider

If you want to change your PCP, you must complete a PCP Change Form. You can get a form and assistance filling it out at your local DSS office. The forms are also available by contacting the Division of Medical Services at (605) 773-3495 and on our Web site.

You may request to change your PCP at any time. You should explain your reason for change on the PCP Change Form. Change requests are usually approved unless the PCP is unavailable or located a long distance from your home. If the change is approved, **your new PCP will become effective the first day of the next month after your change form is received.**

If you move to a new area, contact your local DSS office. This will help ensure that you do not have a break in coverage, your information is current, and will give you a chance to change to a PCP in your new area.

Remember: If you changed your PCP and you have a referral for specialty, hospital or other services from you old PCP, you will need to get a new referral from your new PCP.

Indian Health Services (IHS)

Who is eligible for IHS services?

If you are an American Indian, you can receive medical care from Indian Health Services (IHS) for free. If you are in the Managed Care Program, you can choose IHS as your Primary Care Provider (PCP) or you can choose someone else. Even if IHS isn't your PCP, you can still receive services from IHS without a referral from your PCP.

What if IHS wants to refer me elsewhere?

If IHS is your PCP, IHS can refer you to outside providers. However, if IHS is not your PCP, then IHS cannot refer you to outside providers. Only your PCP can refer you to other providers. The Medical Assistance Program will **NOT** pay the bills for services referred by IHS if they are not your PCP.

Emergency Care

"True" emergency care does not require a PCP referral. You may access "true" emergency care from clinics, physicians, after-hours clinics and hospital emergency rooms.

True Emergencies

A "true" emergency means the symptoms of the medical condition are so severe that any person with an average knowledge of medicine would think the individual's health is in danger unless they are treated immediately. Routine care for minor illness and injury is **Not** a "true" emergency. The medical provider who sees the patient determines if a "true" emergency exists based on federal and state guidelines. You will be responsible to pay the medical bill for non-emergency care unless your PCP provides or prior refers the care. Contact your PCP's office if you are unsure about seeking emergency care.

When should I go to the Emergency Room?

You should only go to the emergency room for "true" emergency care. Do not go to the emergency room for routine care. You may have to pay for routine care received at the emergency room if you do not have a referral from your PCP. Remember, the Medical Assistance Program covers emergency care from clinics, physicians, after-hour clinics and hospital emergency rooms.

Follow-up Care to a True Emergency

Follow-up care, such as doctor's appointments, re-checks and other services provided after the emergency condition is over, needs to be provided or referred by your PCP. Let your PCP know after you receive emergency medical care about all scheduled follow-up care.

Out-of-State Emergencies

Medical Assistance will cover out-of-state emergency services with the same limits as in-state services if the provider accepts South Dakota Medical Assistance.

Baby Care Program

Medical Care for You and Your Baby

Even before you start to look or feel pregnant, your baby needs love and care. You also need care to be healthy. The Baby Care Program can help provide the care both you and your baby need.

The Baby Care Program can help provide a healthy beginning for your unborn child. One way to increase your chance of having a healthy child is through early and frequent prenatal care.

In partnership with the SD Department of Health, the Medical Assistance Program provides services such as:

- Checkups and help with transportation
- Pregnancy assessment (questions about your health)
- Case management (help you get the services you need)
- Prenatal education (teaches you about your pregnancy and how to take care of you and your baby)
- Hospital pre-registration for your baby's delivery
- Referral to other programs

For more information contact your local Department of Social Services office. You can also contact your Community Health Nurse. To find the office closest to you, call 1-800-738-2301.

Recommended Prenatal Care

Routine prenatal visits are usually once a month through the seventh month, every two weeks in the eighth month, and weekly in the ninth month.

When to Schedule Healthy Kids Klub Exams

The following schedule will tell you when your child should have a Healthy Kids Klub exam. Contact your child's PCP to schedule an appointment for this exam.

Suggested Checkup Schedule

General Health Checkups

Birth up to 1 Week
1 Week up to 6 Weeks
6 Weeks up to 3 Months
3 Months up to 5 Months
5 Months up to 8 Months
8 Months up to 11 Months
11 Months up to 14 Months
14 Months up to 17 Months
17 Months up to 20 Months
20 Months up to 24 Months
2 Years
Every Year Until Age 21

Other Types of Checkups

- Dental checkups starting at age 3 and yearly thereafter.
- Vision checkups starting at age 5 and yearly thereafter.
- Ask your child's PCP to determine if hearing tests are needed.
- Tests for lead in your child's blood at ages 12 and 24 months and as directed by your child's PCP.

Recommended Immunization Schedule

Age ▶ / Vaccine ▼	Birth	1 Mo	2 Mos	4 Mos	6 Mos	12 Mos	15 Mos	18 Mos	24 Mos	4-6 Yrs	11-12 Yrs
Hepatitis B	HepB #1	HepB #2			HepB #3						
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP			DTaP	Td
Haemophilus influenzae type b			Hib	Hib	Hib	Hib					
Inactivated Polio			IPV	IPV	IPV					IPV	
Measles, Mumps, Rubella						MMR #1				MMR #2	
Varicella						Varicella					
Pneumococcal			PCV	PCV	PCV	PCV					
Influenza					Influenza (Yearly)						
Meningococcal											MCV4

Managed Care Services

Services with a "Yes" in the PCP Referral column must be provided or referred by your PCP. Services with a "No" are Managed Care Exempt and do not need your PCP's referral.

Medical Services	PCP Referral
Inpatient/Outpatient Hospital Services	Yes
Physician/Clinic Services	Yes
Pregnancy Related Services	Yes
Home Health Services	Yes
Rehabilitation Hospital Services	Yes
Psychiatry/Psychology	Yes
PA's, NP's, Nurse Midwives	Yes
Residential Treatment Facilities	Yes
Durable Medical Equipment	Yes
School District Services	Yes
Ambulatory Surgical Center Services	Yes
Healthy Kids Klub Visits (screening)	Yes
Community Mental Health Centers	Yes
Ophthalmology (not glasses)	Yes
Therapy (Physical, Speech, Occupational)	Yes
Lab/X-Ray Services (at another facility)	Yes
Prescription Drug Services	No
True Emergency Services	No
Family Planning Services	No
Podiatry Services	No
Optometric (Routine Eye Care - Glasses)	No
Chiropractic Service	No
Dental	No
Immunizations	No
Mental Health Services for SED & SPMI recipients	No
Ambulance/Transportation	No
Independent Lab/X-Ray (patient not present)	No
Anesthesiology	No
Chemical Dependency Treatment	No

Responsibilities and Rights

Your Managed Care Responsibilities

- Show your Medical Benefits ID card to all health care providers before you receive any medical services.
- Be courteous and treat medical providers with respect as you would like to be treated.
- Go to your PCP for most of your medical care.
- Obtain a referral (referral card) from your PCP before you go to any other provider for managed care services. If your PCP has not approved the service, Medical Assistance will **NOT** pay the bill.
- Keep your medical appointments. Call the medical provider's office ahead of time if you will be late or can't keep your appointment.
- Contact your eligibility worker about changes in your case or if you have questions.
- Use the emergency room for "true emergencies" only.
- Pay your cost-share (if applicable) and for services not covered by Medical Assistance or not properly referred by your PCP.

Managed Care Beneficiaries Rights

- To be treated with respect and with consideration for your dignity and privacy.
- To receive information on available treatment options and alternatives and to participate in decisions regarding your health care, including the right to refuse treatment.
- To choose your PCP and be given the information and time to do so.
- To receive a copy of your medical records if requested and that they be amended or corrected if they are incorrect.

Healthy Kids Klub

What is the Healthy Kids Klub?

Healthy Kids Klub is a "well-child care" program that helps to prevent illnesses before they happen and provides treatment for any illnesses your child may have. These services are **free*** for children under age 21 who receive Medical Assistance.
*(*There is a minimal cost share at ages 19 and 20.)*

What services does Healthy Kids Klub provide?

The Healthy Kids Klub pays for a variety of checkups including an examination and evaluation of your child's general physical and mental health, growth, developmental and nutritional status, vision, hearing and dental status. Immunization status is also tracked to ensure that your child is up-to-date. Lead screenings may also be done.

Immunizations

No matter where you live, your child is not safe without being properly immunized. If your child needs immunizations, please contact your child's doctor today to schedule an appointment.

Lead Screenings

High lead levels can be very harmful, even deadly, to your child if left undiagnosed. All children eligible for Medical Assistance should receive a lead test at 12 and 24 months of age. Contact your child's doctor for more information on whether your child should receive this test.

Children with Special Health Needs

If your child has a chronic health condition, Children's Special Health Services may be able to help. Call 1-800-738-2301 for more information.

Sterilization	Covers sterilization procedures when all are met: 1. The recipient is at least 21 years old; 2. The recipient is a legally competent individual; 3. The recipient has signed an informed consent form after the recipient's 21st birthday; and 4. 30 to 180 days have passed between when the form was signed and the date of sterilization.
Other Transportation Services	Covers non-emergency transportation services to and from the recipient's home to the closest appropriate medical provider. Mileage allowances are not available for travel within city limits or to the recipient's primary care provider (PCP). Mileage allowances are not based on the location of the chosen PCP or by PCP referrals to locations further than the closest provider. Meal and lodging allowances are only made if an overnight stay is required.
Vision	Covers exam, glasses, frames and contact lenses when necessary for the correction of certain conditions. You can receive replacement eyeglasses only after 15 months have passed and a lens change is medically necessary.
Wheelchair Transportation	Covers non-emergency transportation services for medical treatment to and from the recipient's home to a medical provider, between medical providers, or from a medical provider to the recipient's home. The recipient must be confined to a wheelchair to receive this service.

Confidentiality

All medical information concerning applicants and recipients of Medical Assistance is confidential. Sharing this information is limited to purposes directly connected with the administration of the Medical Assistance Program. Use of the Medical Benefits ID Card by an eligible recipient represents consent and allows for the necessary sharing of information between the Medical Assistance Program and Medical Assistance providers.

Covered Services

Medical Assistance Covered Services

It is your responsibility to ask your medical provider (your doctor, pharmacist, etc.) if Medical Assistance covers particular services. Do **NOT** assume that all medical services are covered and paid for by Medical Assistance. Before Medical Assistance will cover any of the following services, the service **MUST** be determined medically necessary. You will have to pay for services not covered by Medical Assistance.

Ambulance	Covers ground and air ambulance trips, attendant, oxygen and loaded mileage (plus other necessary expenses) when medically necessary to take the recipient to the closest medical provider capable of providing the needed care. **The service will only be covered if another type of transportation would endanger the life or health of the recipient.** A call for an ambulance in the absence of other transportation is not appropriate for non-emergency services.
Chiropractor	Covers only manual manipulation of the spine when X-rays taken verify displacement of the spine. Medical Assistance will not pay for more than 30 manipulations in a 12-month period.
Clinics	Covers medical services and supplies furnished under the direction of a doctor.
Dental	Covers exams, X-rays, cleanings, fillings, and provides limited coverage for root canals, crowns, partial dentures, complete dentures and anesthesia. Pre-authorization is required for most services. **Orthodontic Services:** Orthodontic treatment for children may be covered. In most situations, a child must have an orthodontic condition that would impair the ability to eat, chew and speak. Pre-authorization is required for all orthodontic care.

Diabetes Education	Covers up to 10 hours of initial diabetes self-management education. Also covers two hours per year of follow-up education. Assessment of need and documented physician order required.
Durable Medical Equipment (DME)	Covers reusable equipment that is medically necessary and that complies with set service limits. **Note:** Only one nebulizer every five years per family is allowed. Replacement hearing aids may be provided only after a minimum of three years has elapsed since the original fitting and if the original hearing aids are no longer serviceable. Equipment **NOT** covered includes: exercise equipment; protective outerwear; and personal comfort or environmental control equipment such as air conditioners, humidifiers, dehumidifiers, heaters or furnaces. Medial equipment, other than hearing aids, is provided to nursing home residents by the nursing home.
Family Planning	Covers diagnosis and treatment, drugs, supplies, devices, procedures and counseling for people of childbearing age.
Home Health	Covers nursing care, therapy and medical supplies when provided in the recipient's home.
Hospice	Covers end-of-life care for terminally ill recipients provided by licensed hospice providers.
Hospital	**Inpatient** - Covers room and board, regular nursing services, supplies and equipment, operating and delivery rooms, X-rays, lab and therapy. **Outpatient** - Covers emergency room services and supplies, lab, X-rays and other radiology services, therapy care, drugs and outpatient surgery. **Managed Care Recipients** - See additional (ER) requirements in the Emergency Room Section.

Mental Health	Covers psychiatric and psychological evaluations and individual-group-family psychotherapy for the care and treatment of mental illness or disorders. Counseling is not a covered service.
Nursing Home	Covers room and board, nursing care, therapy care, meals and general medical supplies. Medical Assistance will **NOT** pay for durable medical equipment for residents in a nursing home.
Out-of-State Coverage	When receiving out-of-state services, make sure: 1. The provider is a SD Medical Assistance Provider; 2. If you are a managed care recipient, you must have a referral from your PCP; 3. The services are covered under SD Medical Assistance guidelines. Ask your provider if a service is covered. Medical Assistance will cover out-of-state **emergency** services with the same limits as in-state services if the provider accepts SD Medical Assistance.
Personal Care	Covers basic personal care, grooming and household services, if related to a medical need essential to the patient's health. The service must be provided in the recipient's home. Must be physician ordered.
Physician	Covers medical and surgical services performed by a doctor, supplies and drugs given at the doctor's office, X-rays and laboratory tests needed for diagnosis and treatment.
Podiatry	Covers office visits, supplies, X-rays, glucose and culture check and limited surgical procedures.
Prescriptions	Covers a large range of, but not all, prescription drugs, diabetic supplies, family planning prescriptions, supplies and devices. Does not cover most "over-the-counter" medications or products.
Rehab Hospital	Covers extensive rehabilitative therapy following an illness or injury.